

**NC DIVISION MH/DD/SAS  
2009 MEDICAID SERVICES AUDIT**

<b>PROVIDER NAME:</b>			<b>AUDIT DATE:</b>	
<b>PROVIDER #:</b>			<b>NAME:</b>	
<b>CONTROL #:</b>			<b>SERVICE TYPE:</b>	
<b>MEDICAID #:</b>			<b>PROCEDURE CODE:</b>	
<b>DOB/AGE:</b>			<b>SERVICE DATE:</b>	
<b>RECORD #:</b>			<b>UNITS PAID:</b>	
<b>RATING CODES:</b>	<b>O = No</b> <b>2 = partially met</b> <b>4 = Yes</b>	<b>6 = No service note</b> <b>7 = Unable to identify service provider</b>	<b>8 = Repaid</b> <b>9 = NA</b>	<b>RATING</b>
<b>AUTHORIZATIONS/PERSON CENTERED PLAN (Use rating of "4" or "0" for Q 1-3)</b>				
1. a. Is an authorization in place covering this date of service?				
b. If NO, list dates: FROM _____ TO _____				
2. a. Is there a valid service order for the service billed?				
b. If NO, list dates: FROM _____ TO _____				
3. a. Is the date of service covered by a valid PCP?				
b. If NO, list dates: FROM _____ TO _____				
<b>SERVICE DOCUMENTATION (Use Likert Scale See Instructions):</b>				
<b>(Use rating of "4", "2" or "0" for Q 4-9 and "4" or "0" for Q10—or ratings of 6, 8, or 9 as applicable)</b>				
4. Is the PCP individualized per person?				
5. Is the documentation signed within the designated time frame by the person who delivered the service?				
6. Does the service note(s) relate to goals listed in the PCP?				
7. Does the documentation indicate that the requirements of the service definition/rule were met?				
8. Does the documentation reflect treatment for the duration of service?				
9. Does the service note reflect assessment of progress toward goals?				
10. Are the service notes individualized per person?				
11. Do the units documented match units paid?				
If no write units documented: _____				
<b>QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 11-14—or ratings of 6, 8 or 9 as applicable)</b>				
12. a. Is there documentation that the staff is qualified to provide the service billed?				
b. If NO, list dates: FROM: _____ TO: _____				
13. a. Is an individualized supervision plan in place for paraprofessional and AP staff?			a.	
b. Has the plan been implemented?			b.	
c. If "b" is NO, list dates: FROM: _____ TO: _____				
14. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service?				
b. If NO, list dates: FROM: _____ TO: _____				
15. a. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service?				
b. If NO, list dates: FROM: _____ TO: _____				
<b>COMMENTS:</b>				
<b>AUDITOR:</b>			<b>LME:</b>	